

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000463

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 150

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

15117

25117

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9420.1

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122-0

131-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Length of stay in 1b <u>3 weeks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Mo. Methodist Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>718 N. 7th</u>	
3. NAME OF DECEASED (Type or print) First <u>Lynden</u> Middle <u>Monroe</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1888</u>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Corning, Iowa</u>	
13a. FATHER'S NAME <u>Henry H. Young</u>		14. NAME OF HUSBAND OR WIFE <u>Edith I. Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2810 50419</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis Gen. Severe</u> DUE TO (c) <u>2 years</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour <u>5:15</u> a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <u>Jan 1962</u> to <u>Feb 6 1963</u> and last saw him alive on <u>Feb 6 1963</u>		22a. SIGNATURE (Degree or title) <u>J. L. Mothenhead M.D.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb. 6, 1963</u>	
24. FUNERAL DIRECTOR <u>Hixson Funeral Home - Gower, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 12, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Handell</u>		27. ADDRESS <u>2603 Fredrick</u>	
28. LOCATION (City, town, or county) <u>Lebanon</u>		29. STATE <u>Iowa</u>	

Permit issued 2/6/63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence E. Hixson

Licensed Embalmer No. 5122

P. O. Address Lawer, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.